

MATTERS ARISING

Complications of treatment for cryptosporidial diarrhoea

The recent editorial on *Palliation in AIDS* by George¹ and subsequent Clinico-pathological Conference on the *Complications of treatment of cryptosporidial diarrhoea*² are timely reminders of the limitations and consequences of current AIDS therapy and the need to re-evaluate constantly the goals of AIDS management in each case.

In the Clinico-pathological Conference, bronchopneumonia and cardiac failure from staphylococcal septicaemia were found on necropsy to be the cause of death in a terminally-ill AIDS patient with a Hickman line and documented cryptosporidial diarrhoea. The prolonged presence of the indwelling line (2 months) and the isolation of *Staphylococcus aureus* from this site may have been factors for the later development of disseminated staphylococcal infection.³ However, staphylococcaemia is not recognised as a cell-mediated opportunist manifestation of AIDS, and its occurrence in

this patient suggests an additional co-factor, possibly as a result of drug therapy.

It is now increasingly apparent that the use of myelotoxic drugs in AIDS patients is an important cause of neutropenia-associated opportunist infections. In particular, the antiviral agents zidovudine (AZT) and ganciclovir (DHPG) are known to cause neutropenia,^{4,5} which may result in opportunist infection with *Staphylococcus aureus* (as in this case), *Klebsiella pneumoniae*, *E coli*, *Pseudomonas aeruginosa*, other *Enterobacteriaceae*, as well as disseminated candidosis and aspergillosis. Staphylococcal infections are particularly relevant in this context, since AIDS patients are frequently subjected to a combination of myelotoxic agents and invasive procedures, such as insertion of Hickman lines. HIV infection in groups such as intravenous drug users are also likely to provide additional cases of disseminated staphylococcal infection.⁶

Even if the neutrophil count was monitored in the final months of this patient's life, the palliative use of dexamethasone may have lead to impairment of neutrophil function, with the same consequences. Zidovudine was discontinued two months before the patient died, suggesting that this agent was probably not contributing to the pathological

process.

With the increasing use of myelosuppressive drugs in HIV patients, physicians caring for these individuals should be vigilant to the risk of iatrogenic factors changing the patterns of disease presentation, and anticipate the additional problems that may arise as a consequence of neutropenia-associated opportunist infections.

RKW LAU

Ludwig Institute for Cancer Research,
St Mary's Hospital Medical School,
Norfolk Place,
London W2 1PG, UK

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Cervical infection with *Chlamydia trachomatis*

With great interest, I note two recent splendid publications by Radcliffe *et al.*^{1,2} The theme of both of these articles addresses the practice of obtaining a post treatment test of cure for endocervical chlamydial infection. I agree that test of cure is generally unnecessary following patient compliant therapy. Also, reinfection may be rare during the immediate post treatment period.

Our prospective follow up chlamydial test of cure publication³ may be relevant and noteworthy to substantiate several comments. We serially obtained three *Chlamydia trachomatis* cultures and three enzyme immunoassay (chlamydiazyme) tests from sixty-four patients treated for *C trachomatis* cervicitis with tetracycline. All organisms were non viable

Test of Cure of Genital Chlamydia

